required—not less than 1.5 g. per kilo, which corresponds to 90 g., or more than 3 oz., for a man. This is given by injection of a solution, and, since it is not easy to prepare a solution stronger than 25%, the volume to be injected into a man would be 12 oz., assuming that man was as sensitive as an animal (a rabbit, for example). Urethane is not used even in animals when recovery from the anaesthetic is intended.

Penicillin in Chronic Cystitis

Q.—*Would penicillin be of help in a man aged 75, not fit for operation, suffering from chronic cystitis? If so, in what dosage? There is no obstruction to the outflow of urine.*

A.—This question cannot be answered on the meagre information given. Whether penicillin would be beneficial depends first on the organism responsible for the cystitis, and, secondly on whether there is any condition in the genito-urinary tract which prevents its clearing up—residual urine, a small calculus or diverticulum, infected kidneys, etc. Penicillin is of little help in the commonest form of urinary infection—namely, with a coliform bacillus. If the infection is a mixed one and some of the organisms are penicillin-sensitive, these organisms are likely to disappear after treatment, but the remainder may multiply, so that the final condition of the patient is but little better. Penicillin should not be given blindly.

Trusses

Q.—*A heavily built, moderately active man aged 70 has right scrotal and left inguinal herniae, both self-reducing. Is there an alternative form of control to the rather cumbersome steel spring truss? An appliance with rubber pads and a webbing belt used to be made; would this be satisfactory, and, if so, is it still obtainable?*

A.—Generally speaking the comfort of a truss is inversely proportional to its efficiency, and if by "heavily built" is meant fat it is unlikely that any appliance not based on a steel spring will be satisfactory. Much, however, depends on (*a*) the condition of the patient's musculature, (*b*) the size of his external abdominal rings, and (*c*) the amount of strain involved in his "moderate activity." The rubber-pad truss is still obtainable, but is best suited to the bubonocele type of hernia. As an alternative to the "cumbersome steel spring truss" the vulcanite washable spring truss might be tried. This is malleable and can therefore be fitted to the individual, hence avoiding the need for perineal straps; also it is very light.

Treatment of Oculogyric Crises

Q.—*What is the best treatment for paralysis agitans with severe eye spasms? Hyoscine, pethidine, and ergotamine tartrate, separately, have been tried without result.*

A.—The eye spasms are probably oculogyric crises, in which the eyeballs involuntarily deviate in one direction, usually upwards, for a matter of minutes or maybe hours. The best remedy in such an event is amphetamine, 5 to 15 mg. Previous to the employment of this drug it was usual to get the patient to lie down with eyes bandaged and to take phenobarbitone gr. 1–2 (65–130 mg.). Amphetamine usually proves more efficacious.

Estimation of Uric Acid

Q.—*What is the benefit of estimating plasma uric acid in place of blood uric acid? Is 6 mg. considered normal for plasma?*

A.—Subject to the conditions imposed by the permeability of the capillary endothelium, plasma constituents are in equilibrium with the tissue fluid; plasma concentrations are therefore likely to give a better indication of the cell environment. Transudates and exudates have approximately the same uric acid concentration as plasma. It has been claimed that the analysis of plasma enables a more precise differentiation to be made between gouty and non-gouty individuals. The blood of normal fasting human beings contains 3 ± 1 mg. per 100 ml. of free uric acid, of which the largest fraction is in the plasma (cells 2 ± 1 mg.; plasma 4 ± 1 mg.). The figure of 6 mg. should be regarded as reaching the highest limit of normality.

NOTES AND COMMENTS

Loa loa Infection.—Dr. J. R. H. PASQUAL (Barakin Ladi, Nigeria) writes: The extraction of filaria loa during its subconjunctival passage across the eye is a comparatively simple procedure. Yet the methods commonly employed result in a high percentage of failures, due to the escape of the worm before local anaesthesia is complete or to its concealment behind an inflamed and chemotic conjunctiva. As a long sufferer from this affliction I am convinced that the main causes of failure are (1) too weak a local anaesthetic, (2) too elaborate an operation. For this reason I recommend a 10% solution of cocaine as the anaesthetic and a plain curved surgical needle, bayonet edged, as the only surgical instrument necessary. The strong solution of cocaine rapidly brings the movements of the filaria under control, and the extraction of the worm is effected by simply passing the sharp point of the needle through the conjunctiva and under a coil of the worm, which is then rapidly extracted by withdrawing the needle and worm through the incision made by the sharp edges of the needle. Damage to the conjunctiva is negligible, and the only complication is a painful eye some hours later due to the effects of the cocaine. I might mention that at my own request this method has been employed on myself on five occasions without a failure. One of these extractions was carried out by an inexperienced layman, who, without the help of an anaesthetic, proved very skilful. More elaborate methods have been employed on me, but none has succeeded.

Treatment of Cataract.—Dr. RONALD KERR (West Hampstead, N.W.) writes: The answer to the question on the treatment of cataract (June 21, p. 911) is far too sweeping in its condemnation of medical treatment. Mature cataracts, of course, need operation, but in the early stages the lens changes are reversible, and if the physician can spend time on the case and the patient will co-operate it is usually possible to stay the progress of early senile cataracts and to effect some improvement in some of them. Senile cataract, being a degenerative change, has as its cause any factors leading to lowered health and premature senility. As there are thus many possible causes, it is hardly to be expected that there should be *a* treatment; but this does not mean that any treatment is necessarily futile. One must treat the patient rather than the cataract, and regulation of diet to include adequate quantities of mineral salts, vitamins, and water to drink, avoidance of excessive common salt, reduction of weight where required, hormone therapy, and elimination of foci of infection may all be needed in treatment. If there is also present some other condition, such as rheumatism, which indicates an endogenous infection, treatment should include injections of autogenous vaccines in small doses. (Indiscreetly large doses of such vaccines can cause rapid progress of the cataract.) Treatment can never become purely routine, and it would be interesting to know whether the person who answered the question (who is presumably a surgeon) has any personal experience of determined medical treatment of these early cases.

Urinary Incontinence.—Mr. H. P. WINSBURY-WHITE, F.R.C.S. (London, W.) writes: I am interested in this question and answer concerning incontinence of urine of four years' duration in a man aged 34 (July 5, p. 41). I have examined a considerable number of cases where the onset of the complaint has occurred in adult life. This experience enables me to say that endoscopy which omits urethroscopy is an inadequate examination. My reason for this assertion is that I have found a lesion in the posterior or membranous urethra is commonly present; moreover the way in which the incontinence usually yields to proper treatment of the lesion makes it quite clear how dependent the symptom is upon the urethral pathology.

Corrections

Dr. Ethel A. Orchard writes to point out that in our report of the annual dinner of the Association of Surgeons of Great Britain and Ireland (July 12, p. 79) the Commonwealth Travelling Professorship in Medicine (founded by Mr. Arthur Sims) was incorrectly described as the Commonwealth Travelling Fellowship.

In the bibliography to Dr. J. G. Salter's letter (July 19, p. 108) the reference to Rauch, J. H., and Saayman, L. R., should be *S. Afr. med. J.*, **12**, 885.

All communications with regard to editorial business should be addressed to THE EDITOR, BRITISH MEDICAL JOURNAL, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. TELEPHONE: EUSTON 2111. TELEGRAMS: *Aitiology, Westcent, London.* ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone. Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House, Tavistock Square, W.C.1, on receipt of proofs.
ADVERTISEMENTS should be addressed to the Advertisement Manager, B.M.A. House, Tavistock Square, London, W.C.1 (hours 9 a.m. to 5 p.m.). TELEPHONE: EUSTON 2111. TELEGRAMS: *Britmedads, Westcent, London.*
MEMBERS' SUBSCRIPTIONS should be sent to the SECRETARY of the Association. EUSTON 2111. TELEGRAMS: *Medisecra, Westcent, London.*
B.M.A. SCOTTISH OFFICE: 7, Drumsheugh Gardens, Edinburgh.